MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04848

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two years 12 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 7 yrs 10 mo 12 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Baltimore Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Kate B Amos

3. (b) Social Security Number:

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband ~~or wife~~: John Amos

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 12th 1859

8. AGE: Years: 85 Months: 1 Days: 19 If less than one day: ..... hrs. ..... min.

9. Birthplace (Town, county, and state): Maryland

10. Usual occupation: Home

11. Industry or business:

FATHER — 12. Name: John Wilhelm

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah E Bockerts

15. Birthplace: Maryland

16. Informant: Mrs H E Bollinger

Address: 516 W North Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 5 1945 (month) (day) (year)

Cemetery or crematory: Mt Hope Cemetery

Location: Freeland Balto. Co., Md.

18. Funeral director: Williams Cook Inc

Address: 1217 St Paul St. Balto. Md.

19. May 2 1945 (Date rec'd by registrar) C. Harry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2d 1945 at 7-58 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19th 1937 to May 2d 1945 and that I last saw h[illegible] alive on May 2d 1945

Immediate cause of death	DURATION
Chronic Myocarditis	4 yrs
Due to	
Gen Arteriosclerosis	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: W. D. Gaston M.D. M. D. or other

Address: Sykesville Md Date signed: 5/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-d)

CERTIFICATE OF DEATH

04849

Reg. Diat. No. 24

T

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs 8 mo 15 da

Hospital, Institution, or street address where death occurred Springfield State Hospital

How long in hospital or institution? 6 yrs 8 mo 15 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wash.

City or town Clear Spring Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Mary Elizabeth Ash

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 1855

8. AGE:

Years	Months	Days	If less than one day
90	4		..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation housewife

11. Industry or business at home

FATHER — 12. Name Rudolph Herr

13. Birthplace Maryland

MOTHER — 14. Maiden name Elizabeth ?

15. Birthplace Maryland.

16. Informant George Snyder Address Clear Spring Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8-1945 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Near Clear Spring

18. Funeral director Snyder-Rowland

Address Clear Spring Md.

19. May 6 1945 (Date rec'd by registrar) C. Henry Stouer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5th 1945 at 4:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20th 1938, to May 5th 1945 and that I last saw h[illegible] alive on May 5th 1945

	DURATION
Immediate cause of death Bronchio Pneumonia	4 da
Due to Chronic Myocarditis	—
Due to Cataract & Senilis	10 yr
Other conditions Hypertension	—

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Gaston M.D. M. D. or other

Address Sykesville Md. Date signed 5/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of birth date of deceased is shown on FILM No. G 95 MAY 18 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

04850

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster R.D. # 1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster # 1
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Denton Bachman

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 1 1867

8. AGE: Years	Months	Days	If less than one day
78	2	9	....hrs. ....min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name William Bachman

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Lydia Ann Myers

15. Birthplace Carroll Co. Md.

16. Informant Mrs. Howard Bachman

Address Westminster, Md. R.D. # 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13 1945 (month) (day) (year)

Cemetery or crematory Luther Miller Memorial Cem.

Location Bachmans Valley, Md.

18. Funeral director J.B. Bankard & Son

Address Westminster Md.

19. May 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th 1945; at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7th to May 10th 1945; to ....19.... and that I last saw him alive on or about May 6th 1945.

Immediate cause of death	DURATION
Organic Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Stewart M. D. or other

Address Westminster Md. Date signed May 11

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 1485182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Olive

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Olive

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. Mt. Airy

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARY ELLEN BELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband ~~or wife~~: Luther Bell deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1868

8. AGE: Years	Months	Days	If less than one day
76	6	29	..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: William Johnson

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Eliza Harden

15. Birthplace: Maryland

16. Informant: Family Bible Records

Address

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 5- 24- 45 (month) (day) (year)

Cemetery ~~or crematory~~: Woodville

Location: Woodville, Frederick Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. May 23 19 45 (Date rec'd by registrar) Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1945 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to May 19 1945 and that I last saw h... alive on May 18 1945

Immediate cause of death	DURATION
Carcinoma of Left Breast - Generalized Metastasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

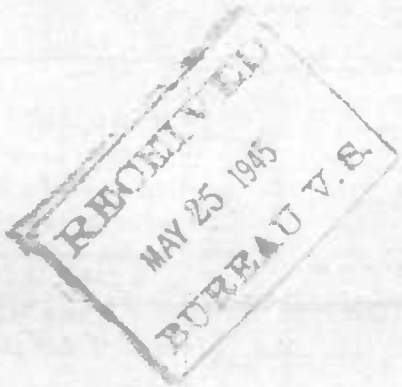
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C M VanPoole M. D. or other

Address: Mt Airy Md Date signed 5/20/45


RECEIVED
MAY 25 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

04852

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr., 2 mo., 13 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 yr., 2 mo., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: John Bernhardt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 6, 1860

8. AGE: Years	Months	Days	If less than one day
85	--	15	hrs. min.

9. Birthplace: Germany
(Town, county, and state)
10. Usual occupation: carpenter
11. Industry or business:

FATHER
12. Name: Conrad Bernhardt
13. Birthplace: Germany

MOTHER
14. Maiden name: Helen Schmidt
15. Birthplace: Germany

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cem.
Location: Balto. Md.
18. Funeral director: Williams Cook Inc.
Address: 1217 St. Paul St.
19. May 21 1945 C. Harry Weed
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1945 at 1:15a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1944 to May 21 1945 and that I last saw him alive on May 20 1945

Immediate cause of death	DURATION
Arteriosclerosis	13 yr.
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	13 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE: Robt Bertrand May, MD
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed 5-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04853

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 1 month, 20 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 644 W. Mulberry St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: SYLVESTER BLACK

3.(b) Social Security Number: 215-16-2724

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Alice Black (Wife)
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): September 13, 1910

8. AGE: Years	Months	Days	If less than one day
34	7	27	..... hrs. ..... min.

9. Birthplace: Fitzgerald, Ga.
(Town, county, and state)
10. Usual occupation: Kitchen Worker
11. Industry or business

FATHER
12. Name: John Black
13. Birthplace: Unknown

MOTHER
14. Maiden name: Estelle ?
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 5/14/45 (month) (day) (year)
Cemetery or crematory: May. 14 1945
Location: Fitzgerald Ga
18. Funeral director: Emile Peter R. Williams
Address: 322 n Schroeder St.

19. May 10, 1945 (Date rec'd by registrar) Albert R. Sweetman Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 1945, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20, 1942 to May 10, 1945
and that I last saw him alive on May 10, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1941
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 5-1-45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04854 74

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 1 day
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 422 N. Carrollton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: LULA BOONE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: John Boone

6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): March 7, 1916

8. AGE:	Years	Months	Days	If less than one day
	29	2	5	....hrs. ....min.

9. Birthplace: Waynesboro, S.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Patterson Peaks
13. Birthplace: Waynesboro, S.C.

MOTHER
14. Maiden name: Ella Blackmore
15. Birthplace: Waynesboro, S.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 5/15/45 (month) (day) (year)

Cemetery or crematory
Location: Waynesboro, S. C.

18. Funeral director: Mrs Katie R. Williams
Address: 322 N. Schnolder St.

19. May 12, 1945 (Date rec'd by registrar) Albert R. Swanhart Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12, 1945 at 7:30P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11, 1945 to May 12, 1945 and that I last saw her alive on May 12, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1940

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 5-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-A)

CERTIFICATE OF DEATH

Reg. Dist. No. 04855 82

1. PLACE OF DEATH:
County: Carroll
City or town: Rural--Winfield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural --Winfield
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Woodbine
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: EVA PEARL BOWER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Thomas M. Bower
6.(c) If alive, give age: 62 years
7. Birth date of deceased (mo., day, yr.): February 1, 1889

8. AGE: Years	Months	Days	If less than one day
56	3	18	....hrs. ....min.

9. Birthplace: Carroll CO. Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Rheuben N. Conaway
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary A. Becker
15. Birthplace: Maryland

16. Informant: Mr. Thomas M. Bower
Address: Woodbine, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 5-11-45 (month) (day) (year)
Cemetery or ~~crematory~~: Bethel Church Of God
Location: near Winfield, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. May 10 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1945 at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2, 1942 to May 9, 1943 and that I last saw her alive on May 9, 1943

Immediate cause of death	DURATION
Cardio-vascular Renal disease	18 years
Due to:	
Due to:	
Other conditions: marked edema	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. Reese Wilkes M. D. or other
Address: R. F. D. Westminster Date signed 5/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04856

Reg. Dist. No. 78

1. PLACE OF DEATH:

County: Carroll

City or town: Rural---Covers Corner

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural --Covers Corner

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. New Windsor

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: FREDERICK A. BROWN**BRAUNGART

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bessie I. Brown--Braungart

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): March 28, 1875

8. AGE:	Years	Months	Days	If less than one day
	70	1	29	....hrs. ....min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

MOTHER FATHER

12. Name: Augustus C. Braungart

13. Birthplace: Unknown

MOTHER

14. Maiden name: Elizabeth Engle

15. Birthplace: Maryland

16. Informant: Mrs. Bessie I. Brown-Braungart

Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-30-45 (month) (day) (year)

Cemetery or crematory: Pipe Creek

Location: near Uniontown, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. May 28 (Date rec'd by registrar) 1945 E. M. Fraser Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1945 at 10 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2nd 1945 to May 27th 1945 and that I last saw him alive on May 27th 1945

Immediate cause of death	DURATION
Paralysis Agitans	1 day
Due to	
Due to	
Other conditions: Chronic Infiltrated Lupus	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. L. Detwiler M. D. or other

Address: New Windsor, Md. Date signed: 5/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04857

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1835 Madison Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: HARRY FRANCIS BROWN, M.D.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28, 1885

8. AGE: Years	Months	Days	If less than one day
60	0	2	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Physician
11. Industry or business:

FATHER
12. Name: Henry F. Brown
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Annie E. Brown
15. Birthplace: Charlottsville, Va.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Buried, Date thereof 6-1-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location: Baltimore County

18. Funeral director: Mrs Frances H Beasley
Address: 598 W. Biddle St

19. May 30, 1945 Albert R Swanhaus Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30, 1945, at 2:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11, 1945, to May 30, 1945 and that I last saw h... im... alive on May 30, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	Feb. 1, 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 5-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

(1)

VS A15

(7)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46a)

CERTIFICATE OF DEATH

04858

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 87 years

Hospital, institution, or street address where death occurred:

Sandymount

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sandymount

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Virginia Shipley Conaway

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	widowed

6.(b) Name of husband or wife: John H. Conaway

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 10, 1858

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
86	7	29		

9. Birthplace: Sandymount, Carroll Co. Md.

(Town, county, and state)

10. Usual occupation: Home - wife

11. Industry or business

FATHER — 12. Name: George W. Shipley

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Martha N. Shipley

MOTHER — 15. Birthplace: Md.

16. Informant: Warner G. Conaway

Address: Finksburg, Md. Carroll Co.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11/45 (month) (day) (year)

Cemetery or crematory: Pleasant Grove Cem.

Location: Sandymount Carroll Co. Md.

18. Funeral director: J. E. Myers Jr.

Address: Westminster, Md.

19. 5/10 19 45 H. Gluesenkamp

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1945 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1945 to May 9, 1945

and that I last saw her alive on May 8 1945

Immediate cause of death	DURATION
Cancer of intestines (probably colon)	1 year
Due to	
Due to	
Other conditions: anemia, mal-nutrition	6 months

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. Reese Wolfenden M. D. or other

Address: Westminster Date signed: 5/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04859

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 20 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Maddox
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARY FLORENCE COUNTISS

3.(b) Social Security Number: 213-22-0465

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1925

8. AGE: Years	Months	Days	If less than one day
19	6	11	hrs. min.

9. Birthplace Maddox, Md. (Town, county, and state)
10. Usual occupation Waitress
11. Industry or business
FATHER 12. Name Benjamin Countiss
13. Birthplace Unknown
MOTHER 14. Maiden name Mary Ellen Parr
15. Birthplace Unknown
16. Informant Reuben Hoffman, M.D.
Address Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-18-45 (month) (day) (year)
Cemetery or crematory Sacred Heart
Location Bushwood Md
18. Funeral director W. C. Mattingley Sons
Address Leonardtown, Md.
19. May 16, 1945 (Date rec'd by registrar) Albert K. Swinkham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1945 at 4:00 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26, 1945 to May 16, 1945 and that I last saw her alive on May 16, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Oct. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 5-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04860

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 12 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 538 N. Eden Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MILDRED DUDLEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 28, 1919

8. AGE:	Years	Months	Days	If less than one day
	25	11	26	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Herbert White
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Jeannette White
15. Birthplace: Baltimore, Maryland

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 28 45 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Baltimore Md.

18. Funeral director: Mrs. Ida Bailey

Address: 1421 Jefferson St.

19. May 24, 19 45 (Date rec'd by registrar) Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24, 19 45 at 12:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12, 19 45 to May 24, 19 45 and that I last saw her alive on May 24, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other

Address: Henryton, Md. Date signed: 5-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05469

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months.
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1507 W. Mulberry St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ALVA MAY EDWARDS

3.(b) Social Security Number: 214-18-7875

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: John Edwards
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1, 1921

8. AGE: Years	Months	Days	If less than one day
24	0	27	hrs. min.

9. Birthplace: BALTIMORE, MARYLAND
(Town, county, and state)
10. Usual occupation: Defense Worker
11. Industry or business:

FATHER
12. Name: Howard Duvall
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Beulah Ward
15. Birthplace: Baltimore, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/3/45 (month) (day) (year)
Cemetery or crematory: Mt. Auburn, Cem.
Location: Mt. Winnen,
18. Funeral director: Mrs. Katie R. Williams.
Address: 322 N. Schroeder St.

19. 5/28/45 (Date rec'd by registrar) 19 Albert R. Sandbach Deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28, 1945 at 9.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 1945 to May 28, 1945 and that I last saw her alive on May 28, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 5-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

04861

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (56)

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ethel V. Edwards

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ Paul H. Edwards

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 28, 1884

8. AGE: Years 61 | Months 2 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation seamstress

11. Industry or business Clothing Factory

FATHER 12. Name Oliver Gerner

13. Birthplace Maryland

MOTHER 14. Maiden name Emma Babylon

15. Birthplace Maryland

16. Informant Mrs. Weldon Mackley

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18, 1945 (month) (day) (year)

Cemetery or crematory Church of God Cemetery

Location Uniontown, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. May 17 1945 (Date rec'd by registrar) Ethele M. Mehring Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945 at 9 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 11 1942 to May 16 1945 and that I last saw h.e.r. alive on May 8 1945

Immediate cause of death	DURATION
Bronchopneumonia, Terminal	2 days.
Due to Pathologic fracture of right femur	6 Mos.
Due to Carcinomatosis	8 Mos.
Other conditions Myxoliposarcoma which began in right posterior tibial region (Include pregnancy within 3 months of death)	3 yrs.

Metastasis to femurs, lungs, pelvis, skull

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D. M. D. or other

Address Taneytown, Md. Date signed 5/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

Within Corporate Limits

CERTIFICATE OF DEATH

04862 76

Reg. Dist. No.

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 YEARS

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: 81 JOHN ST.
(If outside city or town limits, write RURAL and give nearest town)

Street No. WESTMINSTER
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MARTHA A. FOWLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: THOMAS FOWLER

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): AUGUST 25, 1868

8. AGE: Years	Months	Days	If less than one day
76	8	23	..... hrs. ..... min.

9. Birthplace: NEW WINDSOR, MD.
(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business:

FATHER
12. Name: OLIVER A. HULL
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: RACHAEL BOWERS
15. Birthplace: MARYLAND

16. Informant: JENNIE HULL
Address: WESTMINSTER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 5/21/45 (month) (day) (year)

Cemetery or crematory: PIPE CREEK CEM.

Location: CARROLL COUNTY MD

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. MAY 19 1945 (Date rec'd by registrar) F. K. Shoemaker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 18 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1935, to May 18 1945

and that I last saw h.. alive on May 17 1945

Immediate cause of death	DURATION
Carcinoma intestine	
Nephritis (chron)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Jennette M.D.

M. D. or other

Address: Westminster Md Date signed: 5-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04863 74
Reg. Dist. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 24 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium, Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 425 N. Fremont Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: CARRIE GAFFNEY

3. (b) Social Security Number: 242-C5-9645

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 17, 1910

8. AGE: Years	Months	Days	If less than one day
34	6	16	hrs. min.

9. Birthplace: Waynesboro, S.C.
(Town, county, and state)
10. Usual occupation: Defense Worker
11. Industry or business:
FATHER 12. Name: Franklin McKinery
13. Birthplace: Waynesboro, S.C.
MOTHER 14. Maiden name: Hannah Preston
15. Birthplace: Waynesboro, S.C.
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Shipping (Burial, cremation, or removal. Which?) Date thereof 5/6/45 (month) (day) (year)
Cemetery or crematory: Waynesboro S C
Location: " " S C.
18. Funeral director: William a Jackson
Address: 914 Penn Ave
19. May 3, 1945 (Date rec'd by registrar) Albert R. Swartham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3, 1945, at 11:00 M. P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9, 1945, to May 3, 1945
and that I last saw her alive on May 3, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 5-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04864

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 2 months, 3 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 year, 2 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1832 Hope Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Laura Gallagher

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	separated

B.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 22, 1890

8. AGE: Years	Months	Days	If less than one day
54	8	28	hrs. min.

9. Birthplace: Baltimore, Md.

(Town, county, and state)

10. Usual occupation: housework

11. Industry or business

FATHER — 12. Name: Krodel

13. Birthplace: Maryland

MOTHER — 14. Maiden name: unknown

15. Birthplace: Germany

16. Informant: Hospital record

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/23/45 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: Balto. Md.

18. Funeral director: Williams Cook Inc

Address: 1217 St. Paul St. Balto. Md.

19. May 21 19 45 C. Henry Wiese Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 19 45 at 6.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18, 19 44, to May 20 19 45

and that I last saw her alive on May 20 19 45

Immediate cause of death	DURATION
General paralysis of the insane	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Irene Hickman M.D.

M. D. or other

Address: Springfield State Hospital Date signed: 5-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04865

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 215 N. Carey St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ANNA VIRGINIA GALLOWAY

3. (b) Social Security Number: 219-16-7837

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 23, 1917

8. AGE: Years	Months	Days	If less than one day
27	4	18	hrs. mio.

9. Birthplace: Mt. Winans, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: James Galloway
FATHER 13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Carrie Robinson
MOTHER 15. Birthplace: Danville, Va.
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16, 1945 (month) (day) (year)
Cemetery or crematory: Mount Auburn Cemetery
Location: Baltimore City
18. Funeral director: Joseph A. Bendy Funeral Home
Address: 661 West Baltimore St. Baltimore 2, Md.
19. May 11, 1945 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 1945, at 10:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1945, to May 11, 1945 and that I last saw her alive on May 11, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Feb. 1, 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 5-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

04866

Reg. Dist. No. 83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: S. FRANK GARTRELL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALe	White	Married

6.(b) Name of ~~husband~~ or wife: Grace B. Gartrell
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Jan. 16, 1882

8. AGE: Years	Months	Days	If less than one day
63	3	27	...hrs. ...min.

8. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business

FATHER
12. Name: Stephen F. Gartrell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha W. Leatherwood
15. Birthplace: Maryland

16. Informant: Mrs. Grace B. Gartrell
Address: Woodbine, Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 5-15-45 (month) (day) (year)
Cemetery ~~or crematory~~: Morgan Chapel
Location: Day, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. May 14 1945 (Date rec'd by registrar) Edna M. Hewitt Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945 at 3 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1944, to May 13 1945 and that I last saw h... alive on May 12 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage (4th attack)	24 hrs.
Due to: Arteriosclerosis	Years
Due to: Age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. M. Van Pool M. D. or other
Address: Mt Airy Md Date signed 5-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04867

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 5 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1415 Brunt Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN GILES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 23, 1940

8. AGE:	Years	Months	Days	If less than one day
	4	6	14	hrs. min.

9. Birthplace: Nelson County, Virginia
(Town, county, and state)

10. Usual occupation: --

11. Industry or business

FATHER
12. Name: Frank Giles
13. Birthplace: Nelson County, Va.

MOTHER
14. Maiden name: Hattie Talwer
15. Birthplace: Nelson County, Va.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-9-45 (month) (day) (year)
Cemetery or crematory: Arrington, Va.
Location: Va.

18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave.

19. May 7, 1945 (Date rec'd by registrar) Albert B. Counselman Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7, 1945, at 5:35A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1944, to May 7, 1945 and that I last saw him alive on May 7, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	Jan. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 5-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

T 04868

Reg. Dist. No. 8d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lawson Grudstadt Glass

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of ~~husband or~~ wife: Maude L. Glass
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 8-1873

8. AGE:

Years	Months	Days	If less than one day
71	9	5	hrs. ..... min.

9. Birthplace: Sticklersville Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired
FATHER 12. Name: Marcellous M. Glass
13. Birthplace: Virginia
MOTHER 14. Maiden name: Elizabeth Rasnick
15. Birthplace: Virginia
16. Informant: Mrs. Maude L. Glass
Address: New Windsor, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16-1945 (month) (day) (year)
Cemetery or crematory: Keysville Cemetery
Location: Keysville Md.
18. Funeral director: C. W. Hartzler & Sons
Address: Union Bridge & New Windsor Md.
19. May 15 1945 (Date rec'd by registrar) Ernie D Benedict Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7. 1945, to May 13. 1945 and that I last saw him alive on May 11 1945

Immediate cause of death	DURATION
Coronary Thrombosis, acute Cardiac Failure	a few minutes
Due to: Hemiplegia, Hypertension	several years
Due to: arterio-sclerosis	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Edgar R Frantz M.D. M. D. or other
Address: Westminster Md. Date signed: 5/15/1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 526

CERTIFICATE OF DEATH

04869

Reg. Dist. No. .....

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VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Carroll

City or town: Rural #6 Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Route #6 Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: George Herth

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anne Cavell Herth

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): November 15, 1882

8. AGE:

Years	Months	Days	If less than one day
62	5	29	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Retired (44 yrs.) Salesman & V.P.

11. Industry or business: Standard Sanitary Mfg. Co.

FATHER

12. Name: George Herth

13. Birthplace: Germany

MOTHER

14. Maiden name: Bertha Kerchner

15. Birthplace: Germany

16. Informant: Mrs. Anne Herth

Address: Route #6 Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/17/45 (month) (day) (year)

Cemetery ~~or crematory~~: Loudon Park

Location: Baltimore, Md.

18. Funeral director: Wm. J. Tickner & Sons

Address: No. 7 Pa. Aves. Baltimore, Md.

19. 5/16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1945, at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1944, to May 14 1945

and that I last saw h.e.m. alive on May 14 1945

	DURATION
Immediate cause of death: Carcinoma Bladder with metastases	about 2 yrs.
Due to: Secondary Anemia	
Due to: Cachexia	
Other conditions: Leukemoid Hyperplastic	2 da

(Exclude pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. J. Tickner M. D. or other

Address: Westminster, Md. Date signed: May 16, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04870

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 6 months, 2 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Park Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME
AGNES EVELYN HILL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 8, 1929

8. AGE: Years	Months	Days	If less than one day
16	4	6	..... hrs. ..... min.

9. Birthplace Park Hall, Md.
(Town, county, and state)

10. Usual occupation Scholar

11. Industry or business

FATHER
12. Name Arthur Hill
13. Birthplace St. Mary's County

MOTHER
14. Maiden name Elizabeth Hill
15. Birthplace St. Mary's Co.

16. Informant Reuben Hoffman, M.D.
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-19-45 (month) (day) (year)
Cemetery or crematory St Josephs
Location St Marys County Md

18. Funeral director A. Johnson
Address Leonardtown, Md.

19. May 14, 1945 (Date rec'd by registrar) Albert R. Swinnerton Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1945 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 12, 1943 to May 14, 1945 and that I last saw her alive on May 14, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Aug. 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 5-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1 04871

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 years, 22 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 43 years, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward Hodges

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

B.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business

FATHER
12. Name: John P. Hodges
13. Birthplace: Ireland

MOTHER
14. Maiden name: Annie
15. Birthplace: Ireland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17th, 1945 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cemetery
Location: Sykesville, Md.

18. Funeral director: C. Harry Weer
Address: Sykesville, Md.

19. 5-16-1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1945 at 5:50a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to May 15 1945 and that I last saw him alive on May 14 1945

Immediate cause of death	DURATION
Infarct of right lung, less than	24 hrs.
Due to: Chronic myocarditis & myocardial degeneration	7 years
Due to: Arteriosclerosis and hypertension	7 years
Other conditions: Dementia precox, hebephrenic type	44 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: See causes of death, above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 5-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

T 04872

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Smallwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Smallwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. Westminster

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: THOMAS A. HOOD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maggie M. Hood

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): March 16, 1863

8. AGE: Years	Months	Days	If less than one day
82	2	5	...hrs. ...min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: George F. Hood

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah Wolfe

15. Birthplace: Maryland

16. Informant: Mrs. Maggie M. Hood

Address: Westminster, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 5-23-45 (month) (day) (year)

Cemetery ~~or crematory~~: Freedom

Location: Free dom, Carroll Co. Maryland

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. 5/21/45 (Date rec'd by registrar) L. L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21, 1945 at 6;15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1945, to May 21 1945

and that I last saw h... alive on May 19 1945

Immediate cause of death	DURATION
Epithelioma of Right Cheek	Several years
Due to: Chronic arteriosclerosis	about 7 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edgar R Fouts MD M. D. or other

Address: Westminster Md. Date signed 5/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

04873 Reg. Dist. No. 71

MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Union Bridge, Finefrock Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Media Ellen Hoover

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Cyrus A. Hoover

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 14 - 1874

8. AGE: Years	Months	Days	If less than one day
71	3	10	hrs. min.

9. Birthplace: Frederick Co. Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home

FATHER 12. Name: Daniel Delaughter

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Louisa Hoover

MOTHER 15. Birthplace: Maryland

16. Informant: Clinton Hoover

Address: Union Bridge Md Route 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27-1945 (month) (day) (year)

Cemetery or crematory: Immanuel Church Cem

Location: Myersville, Maryland

18. Funeral director: D. D. Hartsbot Jnr

Address: Union Bridge & New Windsor Md

19. May 26 1945 (Date rec'd by registrar) Margaret R. Engler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1945, at 5.30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 1 1945, to May 24 1945; and that I last saw h.. alive on May 23 1945.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. N. Legg M. D. or other

Address: Union Bridge Date signed: 5/24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

J 04874 Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll Co.
City or town Carrollton, near Westminster Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all of life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Carrollton, near Westminster Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Carrollton
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Houck

3. (b) Social Security Number 217-18-8221

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

8.(b) Name of husband or wife Sadie Valentine Houck
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 16. 1870

8. AGE: Years 74 | Months 7 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Carrollton Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Farmer (retired)

11. Industry or business

FATHER 12. Name John Elias Houck
13. Birthplace Maryland

MOTHER 14. Maiden name Martha Mullen
15. Birthplace Maryland

16. Informant Lester A. Houck
Address Carrollton Md. Westminster R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14/45 (month) (day) (year)

Cemetery or crematory Carrollton Church of God Cemetery

Location Carrollton, Near Westminster, Md.

18. Funeral director J. E. Myers Jr.

Address Westminster, Md.

19. 5/14 19 45 — E Reese Wilbern
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 1942 to May 11 1945 and that I last saw him alive on November 1 1944

Immediate cause of death	DURATION
Myocardial degeneration	1 year
Due to Bronchiectasis	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E Reese Wilbern M. D. or other

Address Westminster Md. Date signed 5/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04875

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 2, box 95
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dorothy Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 22, 1923

8. AGE: Years	Months	Days	If less than one day
22	0	5	hrs. min.

9. Birthplace: White Oak, Maryland (Town, county, and state)
10. Usual occupation: --
11. Industry or business

MOTHER
12. Name: Andrew Johnson
13. Birthplace: Charles County, Md.

FATHER
14. Maiden name: Frances Matthews
15. Birthplace: White Oak, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29 45 (month) (day) (year)
Cemetery or crematory: Good Hope
Location: Colesville md
18. Funeral director: Robert L. Swecker
Address: Rockville md

19. May 27, 19 45 (Date rec'd by registrar)
Albert R. Swecker Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 19 45, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3, 19 45 to May 27, 19 45 and that I last saw her alive on May 27, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1939
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 5-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04876

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 7 mo., 16 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Annapolis, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 27 Greeneville St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: RICHARD JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Louise Johnson

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): September 5, 1886

8. AGE:

Years	Months	Days	If less than one day
58	8	8	..... hrs. ..... min.

9. Birthplace: West River, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Nicholas Johnson

FATHER — 13. Birthplace: South River, A.A. Co. Md.

MOTHER — 14. Maiden name: Sophia Arnell

MOTHER — 15. Birthplace: South River, A.A. Co. Md.

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-18-45 (month) (day) (year)

Cemetery or crematory: Burel Hill

Location: West Street

18. Funeral director: Ethel H. Hicks

Address: 45 N.W. St. Annapolis

19. May 13, 45 (Date rec'd by registrar) Albert R. Trueblood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 1945 at 4:45P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 27, 1943 to May 13, 1945 and that I last saw him alive on May 13, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: June 1, 1943

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md. Date signed: 5-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

#4877

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CLARENCE KINSEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Corrie L. Kinsey
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): March 22, 1871

8. AGE: Years	Months	Days	If less than one day
74	1	25	hrs. min.

9. Birthplace: Montgomery Co., Maryland
(Town, county, and state)
10. Usual occupation: Farmer (retired)
11. Industry or business

FATHER
12. Name: Levi R. Kinsey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Christia C. Rabbit
15. Birthplace: Maryland

16. Informant: Mrs. Corrie L. Kinsey
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 5-20-45 (month) (day) (year)
Cemetery ~~or crematory~~: Central
Location: Central, Frederick Co. Md.

16. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. May 19th, 1945 (Date rec'd by registrar) Wm D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17, 1945, at 10. P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 1, 1945, to May 17, 1945 and that I last saw him alive on May 16, 1945

Immediate cause of death	DURATION
Chr. Uremia	3 mo
Due to: Chr. Interstitial Nephritis ?	?
Due to: Arterio-Sclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J Stanley Grabill M. D. or other
Address: Mt Airy, Md Date signed 6/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04878

1. PLACE OF DEATH:
County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 650 South Mosher St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lillie Kyle

3.(b) Social Security Number None

4. Sex Female
5. Color or race Colored
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife John Kyle
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 1870 (Month & Day unknown)
8. AGE: Years 75 Months Days If less than one day ... hrs. ... min.
9. Birthplace Carroll County Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home
FATHER
12. Name Joseph Dunson
13. Birthplace Not Known
MOTHER
14. Maiden name Caroline Woodyard
15. Birthplace Not Known
16. Informant Lester Dunson
Address Union Bridge Maryland R 1
17. Burial Date thereof May 8 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt Joy Cemetery
Location Uniontown Maryland
18. Funeral director D.D.Hartzler & Sons
Address Union Bridge & New Windsor Md
19. May 8, 1945 Leslie [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1945, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 1945, to May 6 1945
and that I last saw her alive on May 5 1945

	DURATION
Immediate cause of death Chronic Myocarditis	
Due to Rheumatism	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE T. H. Legg M. D. or other
Address Union Bridge Date signed 5-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

04879

Reg. Dist. No. 80

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles E Lambert

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Margaret M Lambert

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 16 - 1854

8. AGE:

Years	Months	Days	If less than one day
91	2	24	hrs. min.

9. Birthplace: Carroll County Maryland (Town, county, and state)

10. Usual occupation: Bakery Manager

11. Industry or business

FATHER

12. Name: Jesse F Lambert

13. Birthplace: Maryland

MOTHER

14. Maiden name: Julia ann Miller

15. Birthplace: Maryland

16. Informant: Mrs Edward Lambert

Address: New Windsor, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13 -45 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown Road

19. Funeral director: D. D. Hartle & Son

Address: Union Bridge & New Windsor Md

19 May 12 19 45 Emma Bard Registrar

(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1945 at 5.20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 1945, to May 10 1945 and that I last saw h alive on May 10 1945

	DURATION
Immediate cause of death: Shock	
Due to: Fracture of left hip	
Due to: Accidental fall C.W.&R.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of May 7, 1945

Where did injury occur? New Windsor (City or town) Carroll (County) Maryland (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed: 5-12-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

04880

Reg. Dist. No. 15

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester

(If outside city or town limits, write RURAL and giva nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John W. H. Lambert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife: Sarah A. C. E. Lambert

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 22 - 1862

8. AGE: Years	Months	Days	If less than one day
83	-	3	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Ret Farmer

11. Industry or business

FATHER — 12. Name: John W Lambert

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Angeline E Wolf

MOTHER — 15. Birthplace: Md.

18. Informant: Wm. Lambert

Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28/45 (month) (day) (year)

Cemetery or crematory: Hampstead

Location: Carroll co

18. Funeral director: Edw S Tipton

Address: Hampstead Md

19. May 25 1945 (Date rec'd by registrar) Mrs W. P. S Demer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945 at 2.25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1944 to May 1945

and that I last saw h.im alive on May 23 1945

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Myocardial degeneration	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. V. Sohler M.D. M. D. or other

Address: Manchester Md Date signed: May 25 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
MAY 28 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

04881 K

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years

Hospital, Institution, or street address where death occurred:
180 E. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 180 E. Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rev. James Edward Lowe

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Edith Cramer Lowe

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 21 1881

8. AGE: Years	Months	Days	If less than one day
63	8	0	..... hrs. ..... min.

9. Birthplace Near Westminster Carroll Co. Md
(Town, county, and state)

10. Usual occupation Minister (retired)

11. Industry or business

FATHER 12. Name James Edward Lowe

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Mary Brothers

MOTHER 15. Birthplace Maryland

16. Informant Mrs. J. Edward Lowe

Address 180 E. Main St. Westminster Md

17. Burial Date thereof May 12 45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Johns Leister Cemetery

Location Rural Near Westminster Md

18. Funeral director J. E. Myers, Jr.

Address Westminster, Md.

19. 5/10 19 45 J. Elmer Lund
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1945, at 4.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4th 1930 to May 9 1945 and that I last saw him alive on May 8 1945

Immediate cause of death	DURATION
Epilepsy + acute cardiac dilatation	5 minutes
Due to Epileptic Convulsions	17 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. R. Fouts M.D.
M. D. or other

Address Westminster Date signed 5-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04882 T

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years, 5 mon., 28 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 10 yrs., 5 mon., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2022 St. Paul Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Walter D. MacEwen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Grace Etley
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1889

8. AGE: Years	Months	Days	If less than one day
56			..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Auditor
11. Industry or business:

FATHER
12. Name: John MacEwen
13. Birthplace: Canada

MOTHER
14. Maiden name: Lola S. Justice
15. Birthplace: North Carolina

16. Informant: Mr. Ernest H. MacEwen
Address: 2022 St. Paul Street
17. Burial: Baltimore, Maryland Date thereof: May 5-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Carroll's Chapel
Location: Balto. co
18. Funeral director: J. F. Elmer Sons
Address: Westminster Md.
19. May 3 1945 C. Harvey Zile Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1st 1945 at 9:45A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1944 to May 1 1945
and that I last saw h. alive on May 1 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 yrs.
Due to	
Due to	
Other conditions: Schizophrenia (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Edward F. Kernan M. D. or other
Address: Sykesville, Md Date signed: 5-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

04883

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 5 mos.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs. 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles H. Mayfield

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 13, 1884

8. AGE: Years	Months	Days	If less than one day
61	1	27	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Banker

11. Industry or business: Bank

FATHER — 12. Name: Charles H. Mayfield

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: Ella Kinsey

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: Baltimore Md.

18. Funeral director: John C. Mitchell & Sons

Address: 1700 Eutaw Place

19. May 10 1945 (Date rec'd by registrar) C. Henry Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1945, at 11:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10 1941 to May 10 1945 and that I last saw him alive on May 10 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 mos.
Due to	
Due to	
Other conditions: Manic Depressive Psychosis, Depressed phase (Include pregnancy within 3 months of death)	5 yrs.

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: Springfield State Hosp. Sykesville Md. Date signed 5-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 1
04884
Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 10 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 18 Bobson Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HILDA LENORA MCCREADY

3.(b) Social Security Number: 220-03-0302

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: George McCready
6.(c) If alive, give age: 28 years
7. Birth date of deceased (mo., day, yr.): March 8, 1921

8. AGE: Years	Months	Days	If less than one day
24	2	2	....hrs. ....min.

9. Birthplace: Lakesville, Md. (Town, county, and state)
10. Usual occupation: Factory Worker
11. Industry or business: Unknown
FATHER 12. Name: George Meekins
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Helen Phillips
MOTHER 15. Birthplace: Lakesville, Md.
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13/45 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Woodland Md
18. Funeral director: Lewis F. Rayner
Address: Cambridge Md
19. 5/10 (Date rec'd by registrar) 19 45 Albert R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 1945, at 1.00P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1944 to May 10, 1945 and that I last saw her alive on May 10, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Feb., 9th 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 5/10/45

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

T 04885

CERTIFICATE OF DEATH

Reg. Dist. No. 76

Within Corporate Limits

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 W. Green

(If rural, give LOCATION)

2.(a) If veteran, name war –

3. (a) FULL NAME James Wishard Melown

3. (b) Social Security Number 218-07-8707

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Lillie Sheets

6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Feb. 15 – 1867

8. AGE:

Years	Months	Days	If less than one day
78	3	3	...hrs. ...min.

9. Birthplace Williamsport, Washington Co. Md. (Town, county, and state)

10. Usual occupation ~~Farmer~~ Painter

11. Industry or business

MOTHER FATHER

12. Name John Melown

13. Birthplace Williamsport, Md.

14. Maiden name Sarah E. Grosh

15. Birthplace Williamsport, Md.

16. Informant (Mrs.) Lillie Melown

Address 21 W. Green St. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21 – 1945 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 5/19 1945 [signature] Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1945, at 7:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 16 1944 to May 18 1945

and that I last saw him alive on May 18 1945

Immediate cause of death	DURATION
Cardio Renal disease & myocardial degenerative hypertension	several yrs.
Due to Auricular Fibrillation	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster Md. Date signed 5/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04885 74
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Yrs 23 da
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 11 mo 23 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Garrett Co
City or town: Bayard. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Eva Micheal
3. (b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: G W micheal
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 13th 1855
8. AGE: Years: 89 Months: 11 Days: 10 If less than one day: hrs. min.
9. Birthplace: England (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: at home
FATHER 12. Name: Edwin Burgess
13. Birthplace: England
MOTHER 14. Maiden name: Helen Wright
15. Birthplace: England
16. Informant: Mrs Elsie Barnes
Address: Bayard W Va
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 30 1945 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.
18. Funeral director: C Harry Zeek
Address: Sykesville, md
19. May 30 1945 (Date rec'd by registrar) C Harry Zeek Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1945 at 6-15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 38 1944, to May 22 1945 and that I last saw h.. alive on may 22 1945

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to	
Cerebral Arterio Sclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: Myocarditis + Arterio Sclerosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. H. Gaston M D M. D., or other
Address: Sykesville Md Date signed 5/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

T 04887

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL WESTMINSTER (SMALLWOOD)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: RURAL GAMBER
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: WORLD WAR II

3.(a) FULL NAME: GLENN W. MILLER

3.(b) Social Security Number: 218-18-2356

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): DECEMBER 16, 1922

8. AGE:

Years	Months	Days	If less than one day
22	4	25	..... hrs. ..... min.

9. Birthplace: CARROLL COUNTY, MD.
(Town, county, and state)

10. Usual occupation: LABOR

11. Industry or business

FATHER
12. Name: G. HERSCHEL MILLER
13. Birthplace: MD.

MOTHER
14. Maiden name: DELLA A. ARNOLD
15. Birthplace: MD.

16. Informant: G. H. MILLER
Address: GAMBER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 5/14/45 (month) (day) (year)

Cemetery or crematory: CALVARY CEMETERY

Location: GAMBER, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 5/14 19 45 (Date rec'd by registrar) G. H. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 11, 1945, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/11 1945, to 5/11 1945 and that I last saw h... alive on Did not see, been about

Immediate cause of death	DURATION
Fracture of Skull -	
Due to Automobile Accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 5/11/45

Where did injury occur? Hurlewood (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where?) No -

Means of injury: Automobile Accident Injured at work? No

23. SIGNATURE: Dr. Walter Boa Deputy Med. Examiner
M. D. or other

Address: Westminster - Md. Date signed 5/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

114888 T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 yr., 2 mo. 29 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 48 yr., 2 mo., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Jacob Miller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	unknown

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
about 78			hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: tailor

11. Industry or business:

FATHER 12. Name: Unknown

13. Birthplace:

MOTHER 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-8-45 (month) (day) (year)

Cemetery or crematory: Chev Shalom

Location: O'Donnell St.

18. Funeral director: Jack Lewis Inc

Address: 1439 E. Balto St.

19. May 7 1945 (Date rec'd by registrar) C. Harry Ware Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1945 at 7:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 7 1945 and that I last saw him alive on May 7 1945

Immediate cause of death	DURATION
Chronic Adhesive pericarditis	?
Chronic Myocarditis	?
Due to: Arteriosclerosis	
Due to:	
Other conditions: Dementia precox, hebephrenic type	57 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: See causes of death

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.

Robert Bertrand May M.D.

M. D. or other

Address: Springfield State Hospital Sykesville, Maryland Date signed: 5-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

04889 Reg. Dist. No. 7

1. PLACE OF DEATH:
County: Carroll
City or town: Rural--- Bird Hill
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural --Bird Hill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: R.D. 6 Westminster
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: MELISSA DEAN MILLER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~or wife~~: William E. Miller
Deceased
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19, 1856

8. AGE: Years	Months	Days	If less than one day
88	11	15	hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: John Vial
13. Birthplace: England

MOTHER
14. Maiden name: Mary Catherine Dean
15. Birthplace: Unknown

16. Informant: Mr. George E. Miller
Address: Westminster, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 5--6--45 (month) (day) (year)
Cemetery ~~or crematory~~: Calvary
Location: Gamber, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 5-7-45 (Date rec'd by registrar) 1945 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May. 4 — 1945, at 8:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 7th 1945, to May 4— 1945, and that I last saw h~~er~~ alive on May. 2— 1945.

Immediate cause of death: Acute Cardiac Dilatation — DURATION: 8 hrs
due to: Chronic Myo. carditis — 6 Mos
due to: Chronic arterio sclerosis — 5 yrs
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Ot operations:
Ot autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: L. Bras. R. Fouty, M.D. (M. D. or other)
Address: Westminster, Md. Date signed 5/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on

FILM No. G 9 4 MAY 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04890 T

Reg. Dist. No. 7H

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 5 mos

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs 5 mos 7 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Montg Co.

City or town: Takoma Park (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jeanette Wills

3. (b) Social Security Number

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 15 - 1864

8. AGE: Years: 80 (70) Months: 7 Days: 20 If less than one day: ..... hrs. ..... min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business:

FATHER — 12. Name: Thomas Paton

13. Birthplace: Scotland

MOTHER — 14. Maiden name: Mary

15. Birthplace: Scotland

16. Informant: Douglas Clark

Address: 417 Whittier St. N.W. Wash D C

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 8 1945. (month) (day) (year)

Cemetery or crematory: Cedar Hill Crematory.

Location: Wash. D.C. - Md.

18. Funeral director: J. Arthur Wallace

Address: 254 Carroll Ave N.W. Takoma Park, D.C.

19. May 6 1945 (Date rec'd by registrar) C. Harry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5th 1945 at 9.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 28th 1941 to May 5th 1945 and that I last saw her alive on May 5th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 da
Due to	
Chr. Endocarditis	Yrs.
Due to	
Chr. Arterio Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W. P. Martin M.D. M. D. or other

Address: Sykesville Md. Date signed 5/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04891

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 115 N. Poppleton St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: BEATRICE RICHARDSON

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4, 1918

8. AGE: Years	Months	Days	If less than one day
26	10	21	hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ---

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mamie Suggs
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 5/31/1945 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cemetery
Location: West Port Md.

18. Funeral director: Mrs Katie R. Williams
Address: 3221 N Schroeder St.

19. May 25, 1945 (Date rec'd by registrar) Albert R. Lee Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25, 1945 at 11.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1945 to May 25, 1945 and that I last saw her alive on May 25, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Beb. 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Md Date signed: 5/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 21

CERTIFICATE OF DEATH

04892

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yr., 7 mo., 2 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 10 yr., 7 mo., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William F. Rider

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	

6.(b) Name of husband or wife: Maggie Knox
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 15, 1885

8. AGE: Years	Months	Days	If less than one day
60	3	18	hrs. min.

9. Birthplace: Hagerstown, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Claggett Rider
13. Birthplace: Maryland
MOTHER 14. Maiden name: Alice Semler
15. Birthplace: Maryland
16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland
17. (Burial, cremation, or removal. Which?) Date thereof: May 7 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown Md.
18. Funeral director: F W. Kraiss
Address: Hagerstown Md.
19. May 4 1945 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 19 45, at 9:15p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43, to May 3 19 45 and that I last saw him alive on May 3 19 45

Immediate cause of death	DURATION
Cerebral thrombosis	3 days
Due to	
Due to	
Other conditions: Psychosis with mental deficiency	25 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, MD M. D. or other
Springfield State Hospital
Address: Sykesville, Maryland Date signed: 5-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

T 04893

Reg. Dist. No. 81

1. PLACE OF DEATH:

County Carroll Co.

City or town Rural near Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All her life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural near Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. Priestland School House

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edward Joseph Rinehart, Edward Jeigh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M. M	W.	Married

6.(b) Name of husband or wife Mamie Stitely Rinehart

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 20, 1870

8. AGE: Years 74 | Months 11 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Union Bridge Carroll Co. Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name Israel Rinehart

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Susanna Engler

15. Birthplace Carroll Co. Md.

16. Informant Mrs. Edward J. Rinehart

Address Union Bridge Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2 '45 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location Uniontown, Md.

18. Funeral director J. S. Myers Jr.

Address Westminster Md

19. June 1 1945 Jesse D. Reese Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 1945 to May 30 1945 and that I last saw him alive on May 30 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. N. Legg M. D. or other

Address Union Bridge Date signed 5-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

T

04894

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Greenville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Greenville

(If outside city or town limits, write RURAL and give nearest town)

Street No. or Rural Route No. Oakland Mills, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank Sellman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

6.(b) Name of husband or wife Rachel Benefit

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 10, 1867

8. AGE: Years	Months	Days	If less than one day
77	9	9	....hrs. ....min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business —

FATHER 12. Name — Sellman

13. Birthplace Unk —

MOTHER 14. Maiden name Unk —

15. Birthplace Unk —

16. Informant Mrs Mary Shilliff

Address 1920 Wilhelm Av. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22 1945 (month) (day) (year)

Cemetery or crematory Old Oakland Cem.

Location Carroll Co. Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. May 21 1945 C. Harry Weer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1945, at 8 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to May 19 1945

and that I last saw him alive on May 17, 1945

Immediate cause of death	DURATION
Chr. Sub Hart Disease	5
Due to	
Arteriosclerosis	5.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Ira E. Martin M. D. or other

Address Randallstown Md. Date signed 5/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

T 14895

Reg. Dist. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Middleburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Middleburg (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jacob Stephen Snare

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Betty McKinney Snare 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July - 1874

8. AGE: Years	Months	Days	If less than one day
70	11		hrs. min.

9. Birthplace Baltimore Co., Maryland (Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business Automobile

FATHER 12. Name Adam Snare

13. Birthplace Not Known

MOTHER 14. Maiden name Mary Chetelat

15. Birthplace Not Known

16. Informant Mrs. Betty McKinney Snare

Address Middleburg, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date there May 27-1945 (month) (day) (year)

Cemetery or crematory Hauglas Church Cemetery

Location Woodsboro - Keymar Road

18. Funeral director D. D. Hartle & Sons

Address Union Bridge & New Windsor, Md

19. May 26 1945 (Date rec'd by registrar) P. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945, at 3.00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 20 1945, to May 25 1945 and that I last saw him alive on May 24 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other

Address Union Bridge Md Date signed 7/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

CERTIFICATE OF DEATH

04896

Reg. Dist. No. 78

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Taneytown
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown,
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(n) If veteran, name war

3.(a) FULL NAME Alfred Towne Sutcliffe

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Marion Blocher Sutcliffe

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 21, 1891

8. AGE:	Years	Months	Days	If less than one day
	54	5	5	hrs. min.

9. Birthplace Hummelstown, Pa.
(Town, county, and state)

10. Usual occupation Clergyman

11. Industry or business

FATHER 12. Name Alfred Sutcliffe

13. Birthplace Penna.

MOTHER 14. Maiden name Rebecca Grove

15. Birthplace Penna.

16. Informant Dr. C.M. Benner

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28, 1945 (month) (day) (year)

Cemetery or crematory Evergreen Cemetery

Location Gettysburg, Pa.

18. Funeral director C.O. Fuss & Son

Address Taneytown, Md.

19. May 27, 1945 (Date rec'd by registrar) Ethel M Melvin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 th 1945, at 1 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 th 1945, to May 26 th 1945 and that I last saw him alive on May 25 th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 hours
Due to Arterio Sclerosis	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Benner M D
M. D. or other

Address Taneytown Md Date signed May 26 th 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-E

CERTIFICATE OF DEATH

74897

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 11 days
Hospital, institution, or street address where death occurred:
Md. Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland, County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 927 N. Caroline St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: RUTH CHARLOTTE SWINTON

3.(b) Social Security Number: 222-22-1288

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Elijah Swinton.
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): March 7, 1913

8. AGE: Years	Months	Days	If less than one day
32	2	19	....hrs. ....min.

9. Birthplace: Prince Georges' Co., Va.
(Town, county, and state)
10. Usual occupation: Beautician
11. Industry or business: ----

FATHER
12. Name: Charles Colbert
13. Birthplace: Unknown

MOTHER
14. Maiden name: Marina Jones
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30-1945 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location:

19. Funeral director: Mrs Robert Elliott, daughter
Address: 1179 N. Caroline St.

19. May 26, 19 45 (Date rec'd by registrar) Albert R. Swanhart Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26, 19 45 at 1.10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15, 44 to May 26, 19 45
and that I last saw h...er alive on May 26, 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Aug. 16 1944

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 5/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04898

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 12 Rich Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MYRTLE THORNTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 4, 1926

8. AGE: Years: 18 | Months: 7 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER — 12. Name: Lucelius Thornton
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Carrie Thompson
15. Birthplace: Maryland

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30th/45 (month) (day) (year)
Cemetery or crematory: Mt Calv. Cemetary
Location: Brentland Md

18. Funeral director: Elmer O. Wilson
Address: 1000 E. Brantley St

19. May 27, 1945 (Date rec'd by registrar) Allen M. Swankhan Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 29, 1944 to May 27, 1945 and that I last saw her alive on May 27, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: March 16 1943

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 5-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-d)

CERTIFICATE OF DEATH

7
04899

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos 20 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 8 mos. 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 132 Piloa Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: THOMAS TREZISE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Minnie Trezise

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Oct. 4, 1884

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
60	7	18		

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Coal miner

11. Industry or business: Coal mine

FATHER
12. Name: Sam Trezise
13. Birthplace: England

MOTHER
14. Maiden name: Mary McConnell
15. Birthplace: Maryland

16. Informant: Hospital Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/25/45 (month) (day) (year)

Cemetery or crematory: Westernport

Location: Allegany Co., Md.

18. Funeral director: C. Harry Elwell

Address: Sykesville, Md.

19. May 22 1945 C. Harry Elwell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1945, at 3 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2 1945, to May 22 1945, and that I last saw him alive on May 22 1945

Immediate cause of death	DURATION
Chronic Myocarditis	unknown
Due to	
Due to	
Other conditions Psychosis & Chronic Alcoholism	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D.
M. D. or other

Address: S. H. Hosp. Sykesville, Md. Date signed: May 22, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

04500 T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 11 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. York (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Katie Dwight

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE:

Years	Months	Days	If less than one day
69			..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Housework.

11. Industry or business at home

FATHER — 12. Name Joseph Hellam

13. Birthplace Ga

MOTHER — 14. Maiden name Margaret Wilson

15. Birthplace Ga

16. Informant John C Dwight

Address 419 S Schroeder St Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7 1945 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto. Md.

18. Funeral director William Cook Inc

Address 1210 St. Paul St.

19. May 3 1945 (Date rec'd by registrar) C. Harry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at 7:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1939, to May 3 1945 and that I last saw h alive on May 3d 1945

Immediate cause of death	DURATION
Lobar Pneumonia	2 da
Due to	
Due to Gen Arterio-Sclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W J Weston MD M. D. or other

Address Sykesville Md Date signed 5/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-d

CERTIFICATE OF DEATH

04904 82

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural --Ridgeville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Riggeville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. Mt. Airy

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MARY ELIZABETH WETZEL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: George T. Wetzel

deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 21, 1852

8. AGE: Years	Months	Days	If less than one day
92	9	18	..... hrs. ..... min.

9. Birthplace: Frederick Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Elias Dayhoff

13. Birthplace: Maryland

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Mrs. Clara Naill

Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation~~, or removal. Which?) Date thereof 5-13-45 (month) (day) (year)

Cemetery ~~or crematory~~: Pine Grove

Location: Mt. Airy, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. 5/12 (Date rec'd by registrar) 1945 Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1945, at 9:30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1944, to May 9 1945 and that I last saw h..r alive on May 8 1945

Immediate cause of death	DURATION
Cbr. Myocarditis	2 yrs
Due to: Advanced Arteria-sclerosis	5 yrs
Due to:	
Other conditions: Cardiac Asthma	3 days

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J Stanley Grabill M. D. ~~or other~~

Address: Mt Airy, Md Date signed 5/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

04902

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr., 3 mo., 10 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 yr., 3 mo., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: John Weyer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Daisy L. Stewart
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 24, 1869

8. AGE: Years	Months	Days	If less than one day
75	5	1	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Cutter & marker
11. Industry or business: Shirt manufacturing

FATHER
12. Name: John Weyer
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Kothe
15. Birthplace: —

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 28, 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto. Md.
18. Funeral director: Williams Cook Inc
Address: 1217 St. Paul St.

19. May 25 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to May 25 1945 and that I last saw him alive on May 25 1945

	DURATION
Immediate cause of death: Arteriosclerosis	12 yrs.
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	3 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 5-25-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

64903

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1048 Pennsylvania Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ANNA WHITNEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 2, 1932

8. AGE: Years	Months	Days	If less than one day
12	9	4	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: School

11. Industry or business:

FATHER — 12. Name: William Whitney

FATHER — 13. Birthplace: Harrisburg, Pa.

MOTHER — 14. Maiden name: Jean Wilson

MOTHER — 15. Birthplace: Georgia

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/9/45 (month) (day) (year)

Cemetery or crematory: Arbutus Cemty

Location: Baltimore Md

18. Funeral director: Wm. a. Jackson

Address: 916 Pennsylvania ave

19. May 6, 45 Albert R Swankhaus Deputy Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6, 1945 at 5:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1945 to May 6, 1945 and that I last saw her alive on May 6, 1945

	DURATION
Immediate cause of death: Pulmonary tuberculosis	Dec. 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md. Date signed: 5-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1941

CERTIFICATE OF DEATH

T 04904

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 21 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: Easton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 115 Port Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARY ELLEN WILMER

3.(b) Social Security Number: 219-05-1728

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Married

6.(b) Name of husband or wife: Perry Wilmer
6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): November 6, 1922

8. AGE: Years	Months	Days	If less than one day
22	6	15	....hrs. ....min.

9. Birthplace: Easton, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: James Dickerson
13. Birthplace: Trappe, Md.

MOTHER
14. Maiden name: Mary Brown
15. Birthplace: Philadelphia, Pa.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/24/45 (month) (day) (year)
Cemetery or crematory: Richard cemetery
Location: Easton Md
18. Funeral director: R. Ellis Clark
Address: Easton Md.

19. 5/21/45 (Date rec'd by registrar) 19.... Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21, 1945 at 8:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30, 1944 to May 21, 1945 and that I last saw her alive on May 21, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 5/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

04905 T

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 15 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOHN WESLEY WILSON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Ada Wilson
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): October 15, 1902

8. AGE: Years	Months	Days	If less than one day
42	6	19	...hrs. ...min.

9. Birthplace: Kent County, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: John Wilson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Millie Wilson
15. Birthplace: Chesterville, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 5/5/45 (month) (day) (year)
Cemetery or crematory: University Medical School Morgue
Location: Baltimore Md
18. Funeral director: Mrs Samuel J Hemsley
Address: 578 W. Biddle St

19. May 4, 19 45 (Date rec'd by registrar) Albert R. Swandhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4, 19 45 at 9:15A. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19, 19 42, to May 4, 19 45 and that I last saw him alive on May 4, 19 45

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Jan. 1941
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 5-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04906

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 7 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 108 S. Stockton St.,
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: MAJORIE COOK WILSON

3.(b) Social Security Number: 214-16-4521

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept., 20, 1912

8. AGE: Years	Months	Days	If less than one day
32	7	29	..... hrs. ..... min.

9. Birthplace St. Michaels, Md.
(Town, county, and state)
10. Usual occupation Defense Worker
11. Industry or business

FATHER
12. Name Henry Thomas
13. Birthplace Royal Oak, Md.

MOTHER
14. Maiden name Irene Cook
15. Birthplace Royal Oak, Md.

16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22-45 (month) (day) (year)
Cemetery or crematory St. Michaels (Cem)
Location St. Michaels Md.
18. Funeral director J. Thomas Marshall
Address St. Michaels

19. 5/19 (Date rec'd by registrar) 19 45 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 19 45, at 5.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12, 19 45 to May 19, 19 45 and that I last saw her alive on May 19, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 5/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99)

T 04907

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 21 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wash.
City or town: Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: George Wesley Winters

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 15, 1873

8. AGE: Years	Months	Days	If less than one day
72	3	0	hrs. min.

9. Birthplace: Mercersburg, Pennsylvania
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: John Winters
13. Birthplace: York-

MOTHER
14. Maiden name: Margaret Sharrah
15. Birthplace: York-

16. Informant: Mrs. Lizzie McCune sister
Address: 300 S. Church St., Waynesboro, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17 1945 (month) (day) (year)
Cemetery or crematory: Riverview
Location: Williamsport
16. Funeral director: Aleck V. Leatherman
Address: Williamsport Maryland

19. May 15 1945 (Date rec'd by registrar) C. Harry Dew Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15, 1945, at 5:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 24 1945, to May 15 1945
and that I last saw him alive on May 14 1945

Immediate cause of death	DURATION
Arteriosclerotic gangrene of right foot	6 weeks
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions: Senile Psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward F. Kerman M. D. or other
Address: Sykesville, Md. Date signed 5-15-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING